

<sup>1</sup> 5 U.S.C. §§ 8101-8193.

### **FACTUAL HISTORY**

On February 23, 2012 appellant, then a 38-year-old facts motor vehicle operator, filed a Form CA-1 traumatic injury claim alleging that on February 22, 2013 he injured his low back when lifting a wheelchair with a patient in it up steps. He did not stop work.

Appellant submitted a February 22, 2012 report from Dr. Eromonelel O. Idahosa, a Board-certified internist, who treated appellant for low back pain. He reported assisting a wheelchair bound patient up steps and he felt a pull in his low back. Dr. Idahosa diagnosed low back pain and muscle strain. On October 4, 2012 he treated appellant for low back pain after appellant sustained a new back strain. Lumbar spine x-rays revealed L5-S1 pars defects with minimal anterolisthesis of L5-S1 and age-indeterminate fracture of the coccyx. Dr. Idahosa diagnosed low back pain and old fracture of the coccyx.

On February 23, 2012 appellant was treated by Dr. Vivian S. Howard, a Board-certified internist, for low back pain. He reported pulling a wheelchair up stairs and felt a pull in his back. Dr. Howard diagnosed lumbar strain and released appellant to limited duty. In a March 2, 2012 emergency treatment report, a registered nurse indicated that appellant could return to work with restrictions. On October 5, 2012 Dr. Warren J. Hoyt, a Board-certified internist, treated appellant for ongoing neck and lower back pain. Appellant reported his low back pain began after lifting a 380-pound patient and he felt a pull in his back. An October 11, 2012 magnetic resonance imaging (MRI) scan of the lumbar spine revealed central disc protrusion at L2-3 with disc contact with the traversing L3 nerve roots, and mild grade 2 spondylolisthesis at L5-S1 due to bilateral L5 pars interarticularis defects.

Appellant was also treated by Dr. Amy Leland, a Board-certified physiatrist, for a new injury to his back. In notes dated November 1 and 27, 2012, Dr. Leland noted that he was totally disabled until November 27, 2012. In an attending physician's report dated November 2, 2012, she noted a history of injury on February 22, 2012 and diagnosed right sciatica joint dysfunction and low back pain. Dr. Leland noted with a checkmark "yes" that appellant's condition was caused or aggravated by an employment activity. She found him totally disabled. On November 27, 2012 Dr. Leland saw appellant for low back pain. Appellant reported having a work injury on February 22, 2012 and exacerbated his symptoms on October 4, 2012 causing S1 joint region pain radiating into the low back, episodic bilateral leg, and foot numbness. Dr. Leland noted positive findings on examination and diagnosed sacroiliac joint dysfunction of the right side and low back pain. A December 6, 2012 electromyogram revealed no abnormalities of the lower extremities with no evidence of radiculopathy or peripheral neuropathy.

By letter dated December 26 2012, OWCP advised appellant that his claim was originally received as a simple, uncontroverted case and was administratively handled to allow medical payments up to \$1,500.00, but the merits of the claim had not been formally adjudicated. It advised that, because a claim for wage loss was received, his claim would be formally adjudicated. OWCP requested that appellant submit a comprehensive medical report from his treating physician which included a reasoned explanation as to how the specific work factors or incidents contributed to his claimed low back injury.

Appellant submitted reports from Dr. Leland dated November 1 and 2, 2012 who treated him for chronic neck pain since a 2001 motor vehicle accident and for a recent related work low back injury occurring on February 22, 2012 while pulling a wheelchair bound patient up stairs. He reported that on October 4, 2012 his back symptoms flared up without a specific inciting event and he sought emergency room treatment. Dr. Leland noted findings and diagnosed right side sacroiliac joint dysfunction and low back pain. She found appellant disabled for six weeks. In a January 2, 2013 report, Dr. Leland noted appellant's treatment for right S1 joint dysfunction beginning on November 1, 2012 which he attributed to his injury on February 22, 2012 and an exacerbation of his symptoms from straining his back on October 4, 2012. She opined that the flare-up on October 4, 2012 was due to ongoing repetitive lifting, bending, and twisting. Dr. Leland diagnosed sacroiliac joint dysfunction and low back pain and returned appellant to light duty on January 2, 2013. She indicated that he was not given a diagnosis of right sacroiliac joint dysfunction following his injury on February 22, 2012 and noted the lack of mention of any findings on examination consistent with sacroiliac joint dysfunction until her examination on November 1, 2012. Dr. Leland opined that there was no objective data to indicate that appellant's current diagnosis of sacroiliac joint dysfunction was linked to his February 22, 2012 injury. She concluded that his right sacroiliac dysfunction was the result of repetitive lifting, bending, squatting, and twisting required as part of his job. On January 9, 2013 Dr. Leland increased appellant's stretch breaks from 5 minutes an hour to 10 minutes an hour. On January 16, 2013 she requested an ergonomic chair. In a February 16, 2013, return to work slip, Dr. Leland returned appellant to light-duty work with restrictions on February 6, 2013. A January 23, 2013 excuse slip from Dr. Hoyt noted that appellant was disabled on January 22 and 23, 2013, and could return to work on January 24, 2013.

In a February 8, 2013 decision, OWCP denied the claim on the grounds that the medical evidence did not demonstrate that the claimed medical condition was related to work events.

On March 5, 2013 appellant requested reconsideration. He submitted a November 1, 2012 prescription for physical therapy. A February 6, 2013 report from Dr. Leland noted that appellant had severe deep pain in the right side of his low back with radiation to the hip. Dr. Leland diagnosed lumbago and lumbosacral spondylosis without myelopathy. She recommended lumbar injections. On February 6, 2013 Dr. Leland released appellant to work with restrictions. Appellant submitted a February 15, 2013 report from Dr. Hoyt, who opined that appellant's lumbar disc injury with recurring low back pain and sciatica of the legs was due to a work injury. Dr. Hoyt reported that on February 22, 2012 appellant was injured while lifting a 380-pound patient. He noted that within a reasonable degree of certainty "such an axial overload could have and did injure appellant's lumbar spine, and specifically his discs. Dr. Hoyt advised that the October 11, 2012 MRI scan showed bulging discs contacting three nerve roots. He noted appellant's walking was impaired due to sciatica and he had sacroilitis joint dysfunction "likely" related to the original lifting injury. Dr. Hoyt noted that appellant could return to work with restrictions. In a medical examination report for commercial driver fitness, he noted that appellant was qualified.

In a decision dated May 23, 2014, OWCP denied modification of the decision dated February 8, 2013.

On May 14, 2014 appellant requested reconsideration and submitted evidence from Dr. Hoyt. On June 12, 2013 Dr. Hoyt indicated that appellant could work with restrictions. In a February 7, 2014 report, he noted appellant's complaints of low back and leg pain since February 22, 2012. Dr. Hoyt noted first treating appellant on April 2, 2012 and appellant reported that he felt a pull and pain in his back upon lifting a 380-pound patient in a wheelchair. An MRI scan revealed a central disc protrusion that was consistent with the injury described. Dr. Hoyt indicated that the overly heavy axial spinal loading would have injured appellant's lumbar discs. He asserted that appellant had an injury, his symptoms and MRI scan were consistent with this, and it had an ongoing impact on his ability to work. Dr. Hoyt did not suspect malingering. He opined with a reasonable degree of medical certainty that appellant was injured on the job and continued to have residuals of this injury. Appellant also submitted physical therapy reports.

In a decision dated May 29, 2014, OWCP denied modification of the decision dated May 23, 2014.

### **LEGAL PRECEDENT**

An employee seeking benefits under FECA has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or occupational disease.<sup>2</sup>

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. There are two components involved in establishing fact of injury. First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place, and in the manner alleged. Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.<sup>3</sup>

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.<sup>4</sup>

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<sup>2</sup> *Gary J. Watling*, 52 ECAB 357 (2001).

<sup>3</sup> *T.H.*, 59 ECAB 388 (2008).

<sup>4</sup> *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

## ANALYSIS

It is not disputed that, on February 22, 2012, appellant was lifting a wheelchair bound patient up steps. However, he has not submitted sufficient medical evidence to establish that his diagnosed conditions were caused or aggravated by this incident.

Appellant submitted reports from Dr. Hoyt dated February 15, 2013 and February 7, 2014 who opined appellant's lumbar disc injury with recurring low back pain and sciatica of the legs was work related. Dr. Hoyt reported appellant being injured on February 22, 2012 while lifting a 380-pound patient. He opined that, within a reasonable degree of certainty, such an axial overload could have and did injure appellant's lumbar spine and discs as seen on the October 11, 2012 MRI scan. Dr. Hoyt asserted that appellant was injured on the job and continued to have residuals of this injury. He noted appellant's walking and his ability to work were impaired due to sciatica and he had sacroilitis joint dysfunction "likely" related to the original lifting injury. Although he supported causal relationship, Dr. Hoyt did not provide sufficient medical rationale explaining the basis of his conclusion opinion regarding the causal relationship between appellant's diagnosed conditions and workplace lifting incident. He did not explain how lifting a wheelchair bound patient up steps would cause or aggravate the diagnosed conditions and why the lumbar condition was not caused by nonwork-related factors such as degenerative changes. Additionally, Dr. Hoyt noted the sacroilitis joint dysfunction was "likely" related to the original lifting injury. While this report provides some speculative support for causal relationship,<sup>5</sup> it is insufficient to establish that the diagnosed sacroilitis joint dysfunction was causally related to appellant's employment duties. Dr. Hoyt provided no medical reasoning to support his opinion on causal relationship. Therefore, this evidence is insufficient to meet appellant's burden of proof. On October 5, 2012 Dr. Hoyt noted that appellant reported his low back pain began after lifting a 380-pound patient and he felt a pull in his back and has had recurring back pain. However, he appears merely to be repeating the history of injury as reported by appellant without providing his own opinion regarding whether appellant's condition was work related. To the extent that Dr. Hoyt is providing his own opinion, he failed to provide a rationalized opinion explaining the causal relationship between appellant's low back pain and the factors of employment.<sup>6</sup> Therefore, this report is insufficient to meet appellant's burden of proof. Other reports from Dr. Hoyt are of limited probative value as they too did not specifically support that the work incident caused or contributed to a diagnosed medical condition.<sup>7</sup>

On January 2, 2013 Dr. Leland noted appellant's treatment for right S1 joint dysfunction beginning on November 1, 2012 which appellant attributed to his injury on February 22, 2012 and an exacerbation of his symptoms from straining his back on October 4, 2012. She diagnosed sacroiliac joint dysfunction, lumbago, lumbosacral spondylosis, and low back pain. Dr. Leland

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<sup>5</sup> Medical opinions that are speculative or equivocal in character are of diminished probative value. *D.D.*, 57 ECAB 734 (2006).

<sup>6</sup> *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

<sup>7</sup> *A.D.*, 58 ECAB 149 Docket No. 06-1183 (issued November 14, 2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

indicated that appellant was not diagnosed with right sacroiliac joint dysfunction following his injury on February 22, 2012 and there were no findings consistent with sacroiliac joint dysfunction until her examination on November 1, 2012, and therefore she could not conclude that his current diagnoses were linked to his February 22, 2012 injury. Consequently, this report is of diminished probative value. In a November 2, 2012 attending physician's report, Dr. Leland checked a box "yes" that appellant's condition was caused or aggravated by work activity. However, the Board has held that an opinion on causal relationship which consists only of a physician checking a box "yes" regarding causal relationship is of little probative value. Without any explanation or rationale for the conclusion reached, such report is insufficient to establish causal relationship.<sup>8</sup> Other reports from Dr. Leland are of limited probative value as they did not specifically support that the work incident caused or contributed to a diagnosed medical condition.

Appellant submitted treatment notes from Dr. Idahosa dated February 22, 23, and October 4, 2012 where appellant reported assisting with a wheelchair patient up steps and he felt a pull in his low back. Dr. Idahosa diagnosed low back pain and old fracture of the coccyx. However, he appears merely to be repeating the history of injury as reported by appellant without providing his own opinion regarding whether appellant's condition was work related. In any event, Dr. Idahosa did not provide a rationalized opinion explaining the causal relationship between appellant's lumbar condition and the factors of employment. Therefore, this report is insufficient to meet appellant's burden of proof.

The remainder of the medical evidence, including diagnostic test reports, fails to provide an opinion on the causal relationship between appellant's job and his diagnosed shoulder and back injury. For this reason, this evidence is not sufficient to meet his burden of proof. Appellant also submitted reports from a nurse and physical therapist. However, the Board has held that documents from a nurse or physical therapist are not considered medical evidence as a nurse and physical therapist are not physicians under FECA.<sup>9</sup> Thus, the treatment records from a nurse and physical therapist are of no probative medical value in establishing appellant's claim.

An award of compensation may not be based on surmise, conjecture, or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor the belief that his condition was caused, precipitated, or aggravated by his employment is sufficient to establish causal relationship. Causal relationships must be established by rationalized medical opinion evidence.<sup>10</sup> Appellant failed to submit such evidence, and OWCP therefore properly denied appellant's claim for compensation.

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<sup>8</sup> *Lucrecia M. Nielson*, 41 ECAB 583, 594 (1991).

<sup>9</sup> See *David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as physician's assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

<sup>10</sup> See *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

**CONCLUSION**

The Board finds that appellant did not establish that his claimed conditions are causally related to his employment.

**ORDER**

**IT IS HEREBY ORDERED THAT** the May 29, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 7, 2015  
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge  
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge  
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge  
Employees' Compensation Appeals Board